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No. 96-1375

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
Petitioner,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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BRIEF FOR THE PETITIONER

RONALD N. SUTTER
Counsel of Record
POWERS, PYLES, SUTTER & VERVILLE, P.C.
1875 Eye Street, NW
12th Floor
Washington, DC 20006-5409
(202) 466-6550
Counsel for Petitioner

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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QUESTION PRESENTED

Whether a provision (42 U.S.C. § 1395ww(h)(2)(A)) in 1986 legislation establishing a new Medicare payment methodology for graduate medical education ("GME") costs, which directs the Secretary of Health and Human Services ("the Secretary") to "determine," for a hospital's 1984 cost reporting year, "the average amount [of the hospital's GME costs] recognized as reasonable under this subchapter . . . for each full-time-equivalent resident," requires the Secretary to determine the average using the actual, final "amount recognized as reasonable under this subchapter" for 1984 or whether it authorizes the Secretary to determine the average by reauditing and redetermining the amount of GME costs for 1984 after the reopening and record retention periods for 1984 have expired.

PARTIES TO THE PROCEEDINGS

Petitioner is St. Paul-Ramsey Medical Center, Inc., a not-for-profit teaching hospital located in St. Paul, Minnesota. Petitioner does not have a parent or any non-wholly owned subsidiaries.

Respondent is Donna E. Shalala, Secretary of the Department of Health and Human Services.

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BRIEF FOR THE PETITIONER

OPINIONS BELOW

The opinion of the court of appeals (Petition Appendix ("Pet. App.") 1a-3a) is reported at 91 F.3d 57. The opinion of the district court (Pet. App. 4a-8a) is unreported.

JURISDICTION

The court of appeals entered its judgment on July 26, 1996. Pet. App. 1a. It denied petitioner's petition for rehearing on September 30, 1996. Pet. App. 9a. Justice Thomas granted two extensions of time for filing a writ of certiorari in this case, the second of which extended the time to and including February 27, 1997. Petitioner filed its petition for certiorari on February 27, 1997. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 U.S.C. § 1395ww(h)(2)(A) provides: "The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." So that the Court may review the provision in context, 42 U.S.C. § 1395ww(h) is reproduced in its entirety in the Appendix. In addition, relevant portions of the following are reproduced in the appendix: 42 U.S.C. § 1395oo; 42 U.S.C. §§ 1395ww(a)(1)(C), (a)(4), (b)(3)(A); 42 C.F.R. §§ 405.481(g) (1985), 405.1801(a)(1) (1985), 405.1803(a) (1985), 405.1807 (1985), 405.1885(a) (1985), 412.71(d) (1985), 412.113(b) (1985), and 413.86(e)(1).

STATEMENT

This case presents a straightforward question of statutory construction. At issue is the meaning of a provision in 1986 legislation establishing a new Medicare payment method for graduate medical education ("GME") costs effective for hospital fiscal years beginning on or after July 1, 1985. For all previous years, Medicare had reimbursed teaching hospitals its share of the "reasonable costs" of GME. Under the new method, each year Medicare pays a teaching hospital a percentage, based on the ratio of Medicare patient days to total patient days, of a base year (1984) amount per intern and resident (updated for inflation) multiplied by the hospital's number of full-time-equivalent ("FTE") interns and residents ("residents") during the payment year.

With respect to the base year amount per resident, the statute directs the Secretary to "determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education

costs of the hospital for each full-time-equivalent resident." When the GME statute was enacted in 1986, a long-standing administrative process to establish the amount of GME costs recognized as reasonable for each year, including 1984, had already been established under the Medicare subchapter. Thus, to determine the "average" base year amount per resident under the new payment method, the Secretary had to count the number of FTE residents at the hospital during 1984 and divide the amount of GME costs recognized as reasonable for the hospital for 1984 under the existing process by the number of the hospital's 1984 residents.

By April 1986, when the GME legislation was enacted, the Secretary had issued determinations, under the long-standing administrative process, of the amount of reasonable GME costs for 1984 for some hospitals but not for others. In no case, however, was the determination of the amount of reasonable GME costs for 1984 yet final and binding under the Secretary's rules. All such determinations were still well within the three-year reopening period established under the Secretary's regulations and were subject to revision, if necessary, during that period.

The Secretary waited until September 29, 1989, three and a half years after the statute's enactment, to issue regulations. By that date, many of the determinations of the amount of reasonable GME cost for 1984 (including the determination issued to petitioner) were final, binding, and no longer subject to reopening under the Secretary's own rules, and teaching hospitals were no longer even required to retain audit documentation for 1984 under those rules. Nonetheless, the Secretary issued a regulation (the "reaudit regulation") requiring *reaudits* of the 1984 GME costs recognized as reasonable for those teaching hospitals for purposes of determining their average base year amounts per resident. Thus, for purposes of the new GME payment methodology, the Secretary retroactively abrogated the reopening and record retention standards in her own regulations after expiration of the applicable

limitations periods and placed hospitals in the position of having to reprove costs already proven with finality at a time when many no longer possessed the necessary audit documentation for 1984.

Petitioner challenges the validity of the reaudit regulation. Petiitoner contends that in computing "the average" base year amount per resident under the GME legislation, the Secretary must, under the plain words of the statute, use as the numerator the actual amount of GME costs "recognized as reasonable" under the Medicare subchapter for 1984. The Secretary contends that the statute is "ambiguous" and the purported ambiguity allows her to reopen "final and binding" 1984 audit determinations and reaudit 1984 costs for purposes of establishing the 1984 cost per resident under the GME legislation.

A. Statutory and Regulatory Background.

1. In 1965, Congress enacted the Medicare program primarily to furnish health insurance for the elderly. Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a). From then until 1983, the Medicare program reimbursed participating hospitals its share of the "reasonable cost" incurred in furnishing inpatient hospital services to Medicare patients.[1] 42 U.S.C. § 1395f(b).

[1] The Social Security Amendments of 1965 created two separate insurance programs for Medicare beneficiaries, the Hospital Insurance Benefits program established under part A of title XVIII of the Social Security Act, *see* 42 U.S.C. §§ 426 & 1395c-1395i-4, and the Supplementary Medical Insurance program established under part B of title XVIII, *see* 42 U.S.C. §§ 1395j-1395w-4(j). Part A covers certain "provider" (*i.e.*, institutional) services, including inpatient hospital services. 42 U.S.C. § 1395d(a)(1). The Medicare program has historically paid for these services on a "reasonable cost" basis, "as determined under section 1395x(v)," except in those cases in which a provider's "reasonable costs" exceeded its customary charges. 42 U.S.C. § 1395f(b). Part B generally covers "medical and other health services," 42 U.S.C. § 1395k(a), including phyiscians' services, 42 U.S.C. 1395x(s)(1) (defining "medical and other health services"). The Medicare program has historically paid for these services on a "reasonable charge" basis. 42 U.S.C. § 1395*l*(a).

Hospitals furnishing inpatient hospital services under Medicare received reimbursement for three types of cost: operating, capital, and education. The most significant education costs were the costs incurred for the services furnished by residents in approved training programs, known as GME costs.[2] GME costs included the residents' stipends, teaching physician compensation attributable to the training of residents in approved programs, and support and space costs related to the residency programs. 42 C.F.R. § 405.421(g) (1985) (currently 42 C.F.R. § 413.85(g)). Teaching physician compensation cost was classified as GME cost or operating cost based on physician allocation agreements and supporting records reflect-

[2] Residents in approved GME programs have graduated from medical school and are generally licensed to practice medicine. Ordinarily, physician services are excluded from "inpatient hospital services" under part A, 42 U.S.C. § 1395x(b)(4), and reimbursed under part B, 42 U.S.C. § 1395x(q). However, the services furnished by "an intern or a resident-in-training" in approved teaching programs are included within the definition of "inpatient hospital services," 42 U.S.C. § 1395x(b)(6), and excluded from the definition of "physicians' services," 42 U.S.C. § 1395x(q). Thus, Medicare has always reimbursed the services of residents in approved programs as inpatient hospital services under part A, even though the services of residents in unapproved programs are reimbursed as physician services under part B.

The Medicare statute provides that reasonable cost "shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs" and mandates that both "direct and indirect costs" be taken into account. 42 U.S.C. § 1395x(v)(1)(A). Accordingly, since the inception of the Medicare program, the net cost of approved GME programs has been reported in hospital cost reports pursuant to procedural requirements established in the regulations now codified at 42 C.F.R. §§ 413.1 and 413.20, and has been included in Medicare's determinations of the reasonable cost of inpatient hospital services, *see* 42 C.F.R. § 405.1803, pursuant to the substantive standards established in the regulation now codified at 42 C.F.R. § 413.85.

ing the proportion of physicians' time attributable to residency training programs and the proportion of time attributable to general services furnished to the hospital. 42 C.F.R. § 405.481 (1985). Hospitals were required to retain teaching physician allocation agreements and supporting records for a period of four years after the end of a cost reporting period. *Id.* § 405.481(g) (1985).

2. The Secretary follows a long-established procedure for recognizing costs as reasonable for each cost reporting year. At the close of a year, a hospital participating in the Medicare program, commonly referred to as a "provider," files a cost report with its Medicare fiscal intermediary (the Secretary's agent), which audits the cost report and issues a determination of the hospital's reasonable costs in a notice of program reimbursement ("NPR"). 42 U.S.C. § 1395h; 42 U.S.C. § 1395oo(a)(1)(A)(i); 42 C.F.R. § 413.20; 42 C.F.R. § 405.1803(a)(1); *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399, 400-01 (1988). A provider dissatisfied with the intermediary's determination may appeal to the Provider Reimbursement Review Board ("PRRB" or "Board") and eventually file a court suit. 42 U.S.C. §§ 1395oo(a), (f)(1).

The intermediary's "findings on matters at issue" in an NPR are subject to reopening for a period of three years. 42 C.F.R. § 405.1885(a). Except in cases of fraud, no intermediary finding on the matters at issue in an NPR "may be reopened after such 3-year period." *Id.* If the provider does not appeal and a reopening has not been effected within the three-year period, the intermediary's determination is "final and binding." 42 C.F.R. § 405.1807.

3. Effective with cost reporting years beginning on or after October 1, 1983, Congress adopted a prospective payment system ("PPS") to reimburse most hospitals for inpatient *operating* costs. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e) (enacting 42 U.S.C.

§ 1395ww(d)). PPS does not apply to capital costs or education costs, both of which continued to be reimbursed under "reasonable cost" payment principles. 42 U.S.C. § 1395ww(d)(1)(A) (incorporating the definition of "operating costs of inpatient hospital services" in 42 U.S.C. § 1395ww(a)(4)).

For the first four years of PPS (1984-1987), Medicare paid hospitals a blend of two rates for operating costs—the "hospital-specific rate" and the "federal rate." *Georgetown Univ. Hosp. v. Bowen*, 698 F. Supp. 290, 292-93 (D.D.C. 1987), *aff'd*, 862 F.2d 323 (D.C. Cir. 1988) ("*Georgetown II*"); 42 U.S.C. § 1395ww(d)(1)(A)(i)-(ii); 42 C.F.R § 412.70 (1991). The hospital-specific rate was established for each hospital based on the hospital's operating costs "recognized under this subchapter" for the PPS base year (1982) per patient discharge. 42 U.S.C. §§ 1395ww(d)(1)(A)(i)(I), (ii)(I) (incorporating 42 U.S.C. § 1395ww(b)(3)(A)); 42 C.F.R. § 412.73(a) (1996). The federal rate was an amount per patient discharge based on average national and regional costs during a base year. 42 U.S.C. § 1395ww(d)(1)(A)(i)(II), (ii)(II); 42 U.S.C. § 1395ww(d)(3). Since 1988, hospitals have been paid for operating costs solely on the basis of the federal rate. *Georgetown II*, 698 F. Supp. at 292; 42 U.S.C. § 1395ww(d)(1)(A)(iii).

The Secretary's PPS regulations provided that the hospital-specific rate is "final, and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983" except in very limited circumstances. 42 C.F.R. § 405.474(b)(1)(v) (1983); 42 C.F.R. § 412.71(d) (1985). They also included what is commonly known as the "consistency rule," which specified that the characterization of costs (*i.e.*, operating or medical education) established for the PPS hospital-specific rate must also be used for future years. 42 C.F.R. § 405.477(c)(2) (1983); 42 C.F.R. § 412.113(b) (1985).

4. In 1985, the Secretary issued a regulation which purported to freeze medical education payments for one year at 1984 levels. Under the Secretary's regulation, a hospital's medical education reimbursement for its first cost reporting year beginning on or after July 1, 1985 would have been the lower of its allowable medical education costs for that year or for its cost reporting year beginning in fiscal year 1984 (the base year). 42 C.F.R. § 405.421(a)(2)(i) (1985); 50 Fed. Reg. 27,732 (1985). In the accompanying preamble, the Secretary made clear that the final determination of allowable base year costs for the base year itself would also be used for purposes of the freeze. 50 Fed. Reg. 27,726 (1985).

In April 1986, Congress repealed the Secretary's freeze and adopted a new GME payment methodology (effective for cost reporting years beginning on or after July 1, 1985), based, like the Secretary's regulation, on a hospital's GME costs during fiscal year 1984. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9202. The statute directed the Secretary to calculate an "average" for each hospital. 42 U.S.C. § 1395ww(h)(2)(A). This was to be done by dividing the hospital's GME costs "recognized as reasonable under this subchapter" for 1984 by the hospital's number of residents in 1984. *Id.* For a year subject to the new method, Medicare pays a percentage, based on Medicare patient days to total patient days, of the base year amount per resident adjusted for inflation times the hospital's number of residents during the year.[8] 42 U.S.C. § 1395ww(h).

When the GME legislation was enacted, there were as yet no final and binding determinations of the amount

[8] For instance, if in 1996 a hospital's adjusted base year amount per resident was $60,000, its number of residents was 10, and its Medicare patient load (*i.e.*, Medicare patient days to total patient days) was 25%, Medicare would reimburse the hospital $150,000 ($60,000 x 10 x 25%) for GME.

recognized as reasonable for 1984. In some cases, the Medicare intermediaries had not yet issued NPRs for 1984. In other cases, they had done so, but only shortly before the legislation was enacted. Thus, even where NPRs had been issued, they were still subject to reopening for nearly three years. In addition, hospitals in all cases were still subject to the record retention requirements for the 1984 cost reporting year.

5. On September 29, 1989, the Secretary issued regulations to implement the GME statute. 54 Fed. Reg. 40,286-321, adopting 42 C.F.R. § 413.86, Joint Appendix ("J.A.") 26-38. By that date, the NPR for 1984 had been issued in many cases more than three years earlier. Consequently, in those cases, the amount of GME costs recognized as reasonable in the NPR for 1984 was final, binding, and no longer subject to reopening. 42 C.F.R. §§ 405.1807, 405.1885(a). In addition, by that date hospitals were no longer required to retain the time records necessary for an audit of 1984 GME costs. 42 C.F.R. § 405.481(g)(3) (1995).

Nonetheless, the Secretary did not instruct the intermediaries to use the 1984 GME costs already recognized as reasonable in the normal audit and review process to determine the "average" GME base year amount per resident. Instead, the Secretary issued the reaudit regulation, which directed the intermediaries to reaudit a hospital's 1984 year to redetermine the 1984 GME costs to be used for the GME amount per resident calculation. 42 C.F.R. § 413.86(e)(1)(ii)-(iii).

The regulations state that, if a hospital's cost report for 1984 is no longer subject to reopening under 42 C.F.R. § 405.1885, the Medicare intermediary may apply the reaudited 1984 cost determination *only* for purposes of the GME amount per resident methodology. 42 C.F.R. § 413.86(e)(1)(iii). The intermediary may not, in this instance, use the reaudited 1984 cost determination to

change a hospital's Medicare reimbursement for 1984, which continues to be based on the amount recognized as reasonable in the final NPR for 1984. Thus, in cases where the 1984 reopening period had expired, the regulations authorized the intermediary to determine the average base year amount per resident under 42 U.S.C. § 1395ww(h)(2)(A) by using as the numerator a 1984 GME amount that is different from the amount actually recognized as reasonable for 1984 under the Medicare subchapter. The reaudit regulation retroactively abrogated, for purposes of the GME amount per resident methodology, the Secretary's long-standing reopening regulation, which precluded any reaudit of closed 1984 years.

In the preamble to the reaudit regulations, the Secretary "assure[d] all interested parties that no new reimbursement principles will be applied in the reaudit." 54 Fed. Reg. 40,301 (1989). In fact, however, the Secretary's reaudit regulations themselves made changes to the reimbursement principles in effect in 1984. While affirming the applicability of the consistency rule for an audit of 1984 used to establish GME payment for 1984, the Secretary provided that the consistency rule would not apply to the reaudit of 1984 used to establish 1984 GME costs for purposes of the GME base year amount per resident. 42 C.F.R. § 412.113(b)(3); 42 C.F.R. § 413.86(e)(1)(ii)(B)-(C); 54 Fed. Reg. 40,315-17 (1989), J.A. 26, 29-30.

The Secretary also retroactively amended her regulations governing finality of the PPS hospital-specific rate. She authorized hospitals affected by a reclassification of costs (from GME to operating or vice versa) in the GME reaudit to seek a conforming reclassification for purposes of the hospital-specific rate for PPS years still within the three-year reopening period. 42 C.F.R. § 413.86(j); 54 Fed. Reg. 40,318-19 (1989), J.A. 36-38. She declined,

however, to allow any conforming adjustments to the PPS federal rate. 54 Fed. Reg. 40,301 (1989).

In 1990, the Secretary issued a *Federal Register* notice acknowledging the problem of non-existent records stemming from expiration of the four-year record retention period for 1984. 55 Fed. Reg. 36,063-64 (1990). Specifically, the Secretary noted:

> [C]onsidering the retroactive effect of the change in GME payment policy for cost reporting periods beginning on or after July 1, 1985, we now find that physician allocation agreements, time records and other information may no longer exist for [1984] . . . because the record retention requirements specified in [42 C.F.R.] § 405.481(g) only require the retention of each physician compensation allocation for four years after the end of each cost reporting period to which the allocation applies.

Id. at 36,063. In these instances, the Secretary authorized the intermediaries to use physician time records from a year after 1984, or to use the results of a current three-week time study, for purposes of the 1984 reaudit. *Id.* The intermediaries were directed to use the physician allocation percentages derived from the audit of the later-year time records unless they were higher than the percentages recognized in the NPR for 1984, in which case the intermediaries were to use the lower physician allocation percentages from the 1984 NPR. *Id.*

B. Factual and Procedural History of This Case.

1. Petitioner is a not-for-profit teaching hospital located in St. Paul, Minnesota. Petitioner's GME base year is its cost reporting year ending December 31, 1984. J.A. 17, ¶ 35, & 24, ¶ 35. After conducting a full audit, the Medicare intermediary issued the NPR for petitioner's 1984 fiscal year on February 28, 1986. *Id.*

Three years passed after issuance of petitioner's NPR for 1984 without a reopening related to medical educa-

tion costs or the issuance of regulations implementing the GME legislation. J.A. 17, ¶ 36, & 25, ¶ 36. Accordingly, as of March 1, 1989 (three years and one day after issuance of the NPR), the intermediary's determination of the amount recognized as reasonable for 1984 was "final and binding" and no longer subject to reopening. 42 C.F.R. §§ 405.1807, 405.1885(a). Moreover, as of January 1, 1989 (four years and one day after the close of its GME base year), petitioner was no longer required to retain the physician allocation documentation supporting the GME costs recognized as reasonable in the NPR for 1984. *See* 42 C.F.R. § 405.481(g)(1), (3) (1995); J.A. 17-18, ¶ 37, & 25, ¶37.

The Medicare intermediary nonetheless began reauditing petitioner's 1984 year in late 1990 for purposes of the GME amount per resident methodology. J.A. 18, ¶ 38, & 25, ¶ 38. On February 18, 1991, the intermediary issued a notice of average amount per resident for petitioner's 1984 year. *Id.* The intermediary computed the average amount per resident in that notice by using as the numerator a "reaudited" amount of 1984 GME costs which was lower than the amount recognized as reasonable in the NPR for 1984. *Id.* The Medicare intermediary has used this amount per resident—based on the *1991* reaudit determination of 1984 GME costs, rather than the determination in the NPR for 1984—to reimburse petitioner under the amount per resident methodology for all cost reporting years beginning on or after July 1, 1985.

Petitioner timely appealed the intermediary's notice of average amount per resident to the PRRB. J.A. 18, ¶ 40, & 25, ¶ 40. Petitioner challenged the legality of the Secretary's reaudit regulation, contending that the Secretary must use the amount of GME costs actually recognized as reasonable for 1984 through the normal audit and review process (rather than the reaudit amount)

to determine the average base year amount per resident under the new methodology.

The PRRB ruled that it lacks the authority to decide the validity of the reaudit regulation, thereby allowing petitioner to file a court suit challenging the validity of the regulation.[4] J.A. 19, ¶ 41, & 25, ¶ 41. Petitioner timely filed suit in the U.S. District Court for the District of Minnesota within the period allowed by the Medicare statute. J.A. 19, ¶ 42, & 25, ¶ 42.

2. On August 8, 1995, the district court issued a short opinion upholding the validity of the reaudit regulation. Pet. App. 4a-8a. The court relied on the reasoning in *Administrators of the Tulane Educational Fund v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 510 U.S. 1064 (1994) ["*Tulane*"], and *Toledo Hospital v. Shalala*, No. 3:94CV7080 (N.D. Oh. 1995), a decision that has since been reversed. *Id.* at 7a-8a. In *Tulane*, the D.C. Circuit, relying principally on the fact that Congress in enacting the 1986 statute did not affirmatively *prohibit* the Secretary from discarding the existing administrative process for determining the pertinent costs, *see* Pet. App. 46a, found the statute ambiguous, then upheld it under *Chevron* step two. Pet. App. 38a-54a.

On July 26, 1996, the U.S. Court of Appeals for the Eighth Circuit affirmed in a brief *per curiam* opinion. Pet. App. at 1a-3a. The court concluded that the reaudit regulation "must be upheld for the reasons persuasively stated by the D.C. Circuit in *Tulane*." Id. at 3a. The court noted that "it would have been far preferable had

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[4] The PRRB lacks the authority to invalidate a Medicare regulation. It is legally required to comply with all of the Secretary's Medicare regulations. 42 C.F.R. § 405.1867; *Bethesda Hospital Ass'n*, 485 U.S. at 406. Accordingly, the Medicare statute establishes a procedure under which providers may seek judicial review of any question which the PRRB determines it lacks the authority to decide. 42 U.S.C. § 1395oo(f)(1); J.A. 13-14, ¶¶ 21-23, & 23, ¶¶ 21-23.

the Secretary promulgated the reaudit regulations during the three-year reopening period governing 1984 reimbursements. . . ." *Id.* However, the court concluded that the statute is "ambiguous" and that the Secretary's regulation represents a reasonable measure to ensure the accuracy of base year amounts. *Id.*

3. The U.S. Court of Appeals for the Sixth Circuit subsequently invalidated the reaudit regulation in *Toledo Hospital v. Shalala*, 104 F.3d 791 (1997), *petition for cert. filed*, No. 96-2046 (June 25, 1997), Pet. App. 20a-37a. The *Toledo* court held that the reaudit regulation conflicts with the plain words of the GME legislation and is also unreasonable because it violates principles of issue preclusion and fundamental fairness.

SUMMARY OF ARGUMENT

1. The statute under review is simple and straightforward. It directs the Secretary to determine an average by dividing one number by another. The numerator is the "amount" of a hospital's GME costs "recognized as reasonable under this subchapter" for 1984. The meaning of those words is clear. When the GME statute was enacted, the Medicare subchapter already included a long-standing process for determining the amount recognized as reasonable for each hospital for each year, including 1984. Thus, as the *Toledo* court properly concluded, it follows that Congress intended that the Secretary would use the amount recognized as reasonable for 1984 in the existing process established under the Medicare subchapter to calculate the average amount recognized as reasonable per resident for the base year.

The GME legislation is carefully crafted. Where Congress intended to delegate authority to the Secretary, it did so expressly, using exact and often significantly circumscribed language. For instance, the statute contains an express delegation to the Secretary to establish rules to

count the number of residents and provides copious guidance. In sharp contrast, the statute delegates no authority to the Secretary with respect to the "amount recognized as reasonable under this subchapter" for 1984 except in unusual circumstances as when a hospital was not in existence in 1984 or did not have a GME program in 1984. The absence of a delegation of authority to the Secretary for this component of the GME payment methodology, after numerous express delegations of carefully defined authority with respect to every other component of the payment methodology, demonstrates that the reaudit regulation departs radically from Congress' intent.

Moreover, the reaudit regulation raises numerous issues that Congress—which is presumed to know the existing regulatory and statutory landscape in areas in which it legislates—undoubtedly would have addressed if it had intended the Secretary's construction. These include the procedures to be used for a special reaudit, the evidentiary problems posed by conducting reaudits after expiration of limitations and record retention periods, and the problems of inconsistencies with PPS caused by the Secretary's revocation of the consistency rule. Congress' failure to address these matters, either in the language of the statute or in the legislative history, furnishes compelling evidence that the reaudit regulation conflicts with congressional intent.

The words used in 42 U.S.C. § 1395ww(h)(2)(A) are not unique. Section 1395ww(h) contains other limits or rates based on amounts "recognized under this subchapter" for a base year. In setting those limits and rates, the Secretary has not conducted a special audit for the base year but has used the base year amount recognized through the normal administrative process established under the Medicare subchapter. In *Georgetown II*, the D.C. Circuit held that costs recognized in administrative decisions directly applicable to the base year must also be recognized for the base year amount used to set future

rates, and the Secretary formally acquiesced in that holding. Thus, the reaudit regulation conflicts with the well-established presumption of consistent construction of language within the same statute.

The reaudit regulation adopts a construction that is inconsistent with the plain words of the statute. It therefore fails *Chevron* step one.

2. The reaudit regulation is patently unreasonable and therefore also flunks *Chevron* step two. It conflicts with the principle of issue preclusion and with principles of fundamental fairness. It subjected hospitals to a *new* audit for 1984 after hospitals had already received notice through the established administrative process that the existing determination was final and binding and they were no longer required to retain audit documentation. Hospitals were suddenly required to reprove claims that they had already proven with finality at a time when they were no longer in a position reasonably to do so.

The original NPR determinations issued in 1986 were the products of extensive on-site audits conducted when documentation was readily available, personnel with knowledge of 1984 events were still at the hospitals, and memories were fresh. If the Secretary wished to re-examine those determinations, she had ample time to do so during the normal three-year reopening period. It is not credible that a 1991 reaudit of 1984, conducted after the expiration of limitations and record retention periods, would produce a more accurate result than the 1986 audit of 1984.

The reaudit regulation also resulted in irrational inconsistencies. It produced determinations of 1984 GME costs for the amount per resident methodology that are different than the determinations of 1984 GME costs actually recognized as reasonable for 1984. In addition, by revoking the consistency rule, the reaudit regulation produced cost classifications in the GME reaudits that are inconsistent with those used to establish PPS rates for

operating costs. As a consequence, the cost reclassifications made by the Secretary in the GME reaudits resulted in clearly allowable costs (whether classified as operating or GME) not being reimbursed under either PPS or the GME amount per resident methodology.

3. The reaudit regulation is also invalid because it is an impermissible retroactive rule. It subjected hospitals to a new audit of 1984 conduct after the limitations period for 1984 had expired. It does not matter that the reaudit of 1984 was to establish rates for fiscal years beginning on or after July 1, 1985, and that the reaudit does not directly affect payment for 1984. The reaudits are reaudits of 1984 conduct, not of 1987 or 1990 or 1993 conduct, and thus 1984 is the proper reference point for determining the retroactivity of the reaudit regulation. Viewed from a 1984 perspective, the reaudit regulation is unquestionably retroactive.

"[E]xtending a statute of limitations after the pre-existing period of limitations has expired impermissibly revives a moribund cause of action. . . ." *Hughes Aircraft Co. v. United States*, 65 U.S.L.W. 4447, 4450 (1997). That principle speaks directly to this case. The reaudit regulation extended (indefinitely) the applicable limitations period for 1984 after the limitations period for 1984 had already expired. It also retroactively revoked a determination that was already final and binding. Under this Court's retroactivity precedents, only an express congressional command could warrant such a result. Because even the Secretary concedes that the statute contains no such express command, the reaudit regulation is clearly invalid on retroactivity grounds.

ARGUMENT

I. THE SECRETARY'S REAUDIT REGULATION VIOLATES THE PLAIN MEANING AND CLEAR INTENT OF 42 U.S.C. § 1395ww(h)(2)(A).

The validity of agency constructions of statutes is generally assessed under the familiar two-step approach established in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).[5] The relevant question under the first step is whether Congress' intent is clear. 467 U.S. at 842-43. If so, Congress' intent must prevail. If not, the relevant question under the second step is whether the agency's construction is reasonable. *Id.* at 843.

In applying *Chevron* step one, the Court does "not start from the premise that [the statutory] language is imprecise." *United States v. LaBonte*, 117 S.Ct. 1673, 1677 (1997). Instead, the Court assumes that "Congress said what it meant" and grants Congress' words their "ordinary meaning." *Id.* "The plainness or ambiguity of statutory language is determined by reference to the language itself, the specific context in which that language is used, and the broader context of the statute as a whole." *Robinson v. Shell Oil Co.*, 117 S.Ct. 843, 846 (1997). Application of these principles to the question of construction in this case leads to the unmistakable conclusion that Congress intended the Secretary to determine the average base year amount per resident by using as the numerator the base year amount recognized as reasonable through the existing process established under the Medicare subchapter many years earlier.

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[5] For the reasons discussed in § III below, petitioner contends that the "clear statement" standard in *Landgraf v. USI Film Products*, 114 S.Ct. 1483 (1994), not the *Chevron* standard, applies in this case. However, in §§ I-II, petitioner will assume, for purposes of argument, that the *Chevron* standard applies.

A. The Reaudit Regulation Conflicts With the Ordinary Meaning of the Words in 42 U.S.C. § 1395ww(h)(2)(A).

The GME statute prescribes several steps for computing a hospital's payment rate under the GME amount per resident methodology. This case involves the first step. The relevant paragraph provides:

> The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

42 U.S.C. § 1395ww(h)(2)(A).

This is not a complex provision. The statute directs the Secretary to calculate an "average." As all agree, she does this by dividing (A) the "amount recognized as reasonable under this subchapter" for a hospital's 1984 cost reporting year by (B) the hospital's number of FTE residents for that period. The words "amount recognized as reasonable under this subchapter" have a plain and fixed meaning, and, when read in context, quite clearly direct the Secretary to calculate the average using as the numerator the amount established under the existing administrative process for recognizing such amounts. The Secretary's reaudit regulation discards that process and thus conflicts with the plain intent of Congress.

Contrary to the Secretary's self-serving construction, the meaning of the words "amount recognized as reasonable under this subchapter" is clear. The referenced "subchapter" is subchapter XVIII of the Social Security Act, which "subchapter" is often referred to as the Medicare statute. Subchapter XVIII contains a long-established process for determining the amount of Medicare payment

recognized as reasonable for *each* hospital for *each* year. *See Bethesda Hospital Ass'n*, 485 U.S. at 400-01; *Hospital Ass'n of Rhode Island v. Secretary of HHS*, 820 F.2d 533, 534 (1st Cir. 1987); *HCA Health Servs. of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 615, 617 (D.C. Cir. 1994). It directs the Medicare intermediary to make a "final determination" (the NPR) as to each hospital's payment entitlement for each cost reporting year. 42 U.S.C. § 1395oo(a)(1)(A)(i); 42 C.F.R. §§ 405.1801 (a)(1), 405.1803(a)(1), (b) (1985). A hospital dissatisfied with this determination has 180 days to appeal to the PRRB. 42 U.S.C. § 1395oo(a)(3); 42 C.F.R. §§ 405.1803(b), 405.1835(a) (1985). The intermediary may reopen a final determination of a provider's reasonable costs, "with respect to findings on matters at issue in such determination," within a three-year period. 42 C.F.R. § 405.1885(a) (1985). Once that period expires, the determination is "final and binding," unless timely appealed. 42 C.F.R. § 405.1807 (1985).

As part of the base year audit, the Secretary determined the amount of GME costs "recognized as reasonable" under this regulatory process. However, she did not, in the base year audit, determine the number of residents for GME purposes, and thus she obviously did not determine the *average* amount "recognized as reasonable" *per resident*. Thus, to implement the new payment methodology, the Secretary needed to determine the number of residents (a matter addressed by 42 U.S.C. § 1395ww (h)(4)) and do a mathematical calculation not done for the base year audit, *i.e.*, divide the GME costs "recognized as reasonable" in the base year audit by the number of residents to produce the *average* base year amount per resident. But the determination of this average in no way required, or allowed, the Secretary to "redetermine" the numerator. As the *Toledo* court correctly concluded, 42 U.S.C. § 1395ww(h)(2)(A) is "not at all complex" and

"merely directs the Secretary to divide one number by another." [6] *Toledo*, Pet. App. 31a.

Congress is presumed to know the law in the areas in which it legislates. *See Bowen v. Massachusetts*, 487 U.S. 879, 896 (1988) ("the well-settled presumption [is] that Congress understands the state of existing law when it legislates"); *Goodyear Atomic Corp. v. Miller*, 486 U.S. 174, 184-185 (1988) ("We generally presume that Congress is knowledgeable about existing law pertinent to the legislation it enacts."); *ICC v. Texas*, 479 U.S. 450, 458 (1987) ("Presumably, in enacting § 10505, Congress was aware of the Commission's consistent practice of regulating railroads as 'rail carriers' even when they performed Plan II intermodal service."). *Accord Director, OWCP v. Perini North River Assocs.*, 459 U.S. 297, 319-320 (1983). The Sixth Circuit was therefore clearly correct in concluding:

> When Congress passed the GME amendment in 1986, it knew that there was an administrative scheme in place that would determine the reasonable GME costs for providers for fiscal 1984. . . . It follows that Congress must have contemplated that the Secretary would use those administratively determined reasonable costs as the basis for calculating the average GME cost per full-time-equivalent resident.

Toledo, Pet. App. 30a-31a. Thus, the words "amount recognized as reasonable under this subchapter" can mean

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[6] The *Tulane* court suggested that "determine" is an "activist" word that is reasonably construed as authorizing the Secretary to conduct a special reaudit of 1984 GME costs. 987 F.2d at 796 n.6. But for purposes of establishing an "average," "determine" is no more "activist" than "compute" or "calculate." *Directing the Secretary to "determine" an "average" by dividing (A) by (B) does not authorize the Secretary to "redetermine" (A).* "Determine" is an "activist" word only under an "activist" construction that departs from the word's ordinary meaning when used in the context of determining an average.

only one thing, *i.e.*, the amount established through the normal administrative process, which, in the absence of an appeal or a timely reopening, is the amount established in the NPR.

That conclusion not only comports with the natural meaning of the words used but is eminently reasonable. When the GME legislation was enacted, there were no "final and binding" determinations of the amount recognized as reasonable for 1984. The intermediaries were either in the process of auditing the base year or had just recently issued NPRs. Even where NPRs had been issued, the base year remained subject to reopening for almost three years. Thus, as the Sixth Circuit concluded, the natural construction of the statute is consistent with the aim of ensuring that the 1984 costs were accurate. *Toledo*, Pet. App. 31a-32a. To compute the average, all the Secretary was required to do with respect to 1984 costs was use the "amount recognized as reasonable" in the process long established under the Medicare subchapter. *Id.*

Tellingly, to effectuate her construction, the Secretary effectively had to revoke her own limitations and document retention periods after they had expired. Consequently, hospitals were suddenly—and quite unexpectedly—placed in the position of having to reprove claims they had already proven with finality at a time when many hospitals no longer possessed, and were not required to possess, the necessary documentation. The plain meaning of the 1986 statute, especially when read in context, does not allow the Secretary to repudiate the existing process for recognizing 1984 costs and invent a new one.

"[W]here a common-law principle is well established, as are the rules of preclusion . . ., the courts may take it as given that Congress has legislated with an expectation that the principle will apply except 'when a statutory purpose to the contrary is evident.'" *Astoria Federal Savings and Loan Ass'n v. Solimino*, 501 U.S. 104, 108

(1991). The reaudit regulation defeats that expectation. *Toledo*, Pet. App. 33a.

B. Reading 42 U.S.C. § 1395ww(h)(2)(A) in the Context of the GME Legislation as a Whole and of Other Provisions in the Medicare Statute Mandates a "Plain Meaning" Construction.

1. The absence of a delegation of authority with respect to the words "amount recognized as reasonable under this subchapter" in 42 U.S.C. § 1395ww(h)(2)(A) contrasts with the explicit authority conferred on the Secretary in numerous other sections of the GME legislation.

The provision at issue in this case is only one of many provisions in the GME legislation (42 U.S.C. § 1395ww (h)). The legislation is carefully crafted. At numerous points, Congress recognized the necessity of delegating authority to the Secretary and did so explicitly. At other points, Congress defined its intent with specificity and withheld a delegation of authority to the Secretary.

A prime example of a delegation of authority to the Secretary is found in 42 U.S.C. § 1395ww(h)(4) regarding the resident count (*i.e.*, the denominator in the base year amount per resident formula and the multiplier in years subject to payment under the GME statute). A resident count had no bearing on Medicare reimbursement for GME under the "reasonable cost" payment system in effect in 1984, and thus the Secretary had never established a methodology, under "reasonable cost" principles, to determine the number of residents. Accordingly, Congress expressly authorized the Secretary to establish rules "for the computation of the number of full-time-equivalent residents in an approved medical residency training program" and furnished over 400 words of detailed guidance. 42 U.S.C. § 1395ww(h)(4). The legislation contains at least ten other express delegations of

authority to the Secretary, always defined with exactitude and often significant circumscription.[7]

Under the GME legislation, several elements establish the amount of a hospital's GME payment for a particular

[7] (1) § 1395ww(h)(1) requires the Secretary to "provide for an allocation" of GME payments between the two parts of Medicare (A and B) and furnishes guidance for doing so; (2) with respect to the inflation factor to be used for future years, § 1395ww(h)(2)(D) directs the Secretary to make "appropriate adjustments to reflect previous under- or over-estimations . . . in the projected percentage change in the consumer price index"; (3) for a hospital not in existence in 1984 or without an approved GME program in that year, § 1395ww(h)(2)(E) directs the Secretary, in the first year the hospital begins an approved residency training program, to "provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs"; (4) § 1395ww(h)(3)(C) bases the "medicare patient load" on a fraction, the denominator of which is "the total number of inpatient-bed-days (as established by the Secretary)"; (5) § 1395ww(h)(5)(A) defines "approved medical residency training program" to include "formal postgraduate training programs in geriatric medicine approved by the Secretary"; (6) § 1395ww(h)(5)(D)(iii) defines a "foreign medical graduate" to exclude a graduate of "a school of dentistry or podiatry which is accredited (or meets the standards for accreditation) by an organization recognized by the Secretary for such purpose"; (7) § 1395ww(h)(5)(F)(ii) defines the term "initial residency period" to provide special treatment for a resident "in a geriatric residency or fellowship program or a preventive medicine residency or fellowship program which meets such criteria as the Secretary may establish"; (8) § 1395ww(h)(5)(G)(iii)(I) delegates to the Secretary the authority, under carefully defined circumstances, to "increase the period of board eligibility" for a residency specialty program; (9) § 1395ww(h)(5)(G)(iii)(II) delegates to the Secretary the authority, again under carefully defined circumstances, to "decrease the period of board eligibility" for a residency specialty program; and (10) for a hospital that received government funds (other than Medicare or Medicaid) for the operation of a residency program in 1984, § 1395ww(h)(5)(J)(i)(I) requires the Secretary to "provide for an average amount under paragraph (2)(A) that takes into account the Secretary's estimate of the amount that would have been recognized as reasonable under this subchapter if the hospital had not received such funds."

year: (A) the hospital's 1984 GME costs are divided by (B) the number of the hospital's 1984 FTE residents to produce an average base year amount per resident; that average is multiplied by (C) an inflation factor; the adjusted base year average is multiplied by (D) the hospital's number of FTE residents in the payment year; and finally (E) an apportionment is made between Medicare part A and Medicare part B. The statute delegates clearly defined authority to the Secretary for elements (B)-(E). Indeed, it even delegates authority to the Secretary with respect to element (A), 1984 GME costs, in unusual circumstances—where a hospital was not in existence in 1984 or did not have a GME program in 1984 (42 U.S.C. § 1395ww(h)(2)(E)) and where a hospital was receiving payment for GME in 1984 from a government program other than Medicare or Medicaid (42 U.S.C. § 1395ww(h)(5)(J)(i)(I)). Except in those instances, however, the statute delegates no authority to the Secretary with respect to 1984 GME costs recognized as reasonable under the Medicare subchapter.

The numerous specific delegations of meticulously-defined authority in the GME legislation show that when Congress intended to delegate authority to the Secretary, it did so expressly and deliberately. Yet the GME statute contains not a single word conferring any authority on the Secretary to conduct a special audit for, or make a new determination of, or in any way amend, the GME costs recognized as reasonable under the Medicare subchapter for 1984. Thus, the *Tulane* district court was clearly correct in finding that the "conclusion that Congress did not intend to authorize a reaudit follows naturally when looked at within the framework of the provision as a whole." *Methodist Hospitals of Memphis v. Sullivan*, 799 F. Supp. 1210, 1218 (D.D.C. 1992), *rev'd*, *Tulane*. Numerous precedents of this Court support the district court's logic. *See, e.g., City of Chicago v. Environmental Defense Fund*, 114 S. Ct. 1588, 1593 (1994) ("'[I]t is generally presumed

that Congress acts intentionally and purposely' when it 'includes particular language in one section of a statute but omits it in another' "); *INS v. Cardoza Fonseca*, 480 U.S. 421, 432 (1987) (" '[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.' "). Here, the omission of a delegation of authority in 42 U.S.C. § 1395ww(h)(2)(A) contrasts with the inclusion of a delegation in not just "one section of the statute" but in at least eleven sections of the statute.[8]

The Medicare statute and regulations long ago established the process by which the Secretary determines the amount of GME costs recognized as reasonable for each cost reporting year. If Congress had intended, when it enacted the GME legislation, for the Secretary to bypass that process and create a new process, it surely would have said so. *See Director, Office of Workers' Compensation Programs v. Newport News Shipbuilding and Dry Dock Co.*, 115 S. Ct. 1278, 1288 (1995) ("The withholding of agency authority is as significant as the granting of it, and we have no right to play favorites between the two"). Congress did not do so.

[8] The Secretary seems to be searching for a statutory basis for her purported authority to issue the reaudit regulation. In the *Federal Register* preamble, she expressly disavowed reliance on her general rulemaking authority to issue the reaudit regulation. Specifically, the Secretary stated: "Here the agency is not relying on our general grant of rulemaking authority to support retroactive application, but, rather, on a specific congressional enactment [the GME statute]." 54 Fed. Reg. 40,314 (1989). In court, however, the Secretary invoked instead her general rulemaking authority in 42 U.S.C. § 1395hh(a). *See* Brief of Defendant Appellee at 18-19. An agency's general rulemaking powers, of course, do not confer on the agency the authority to override Congress' clear intent. *Board of Governors of Fed. Res. Sys. v. Dimensions Financial Corp.*, 474 U.S. 361, 374 (1986). Moreover, 42 U.S.C. § 1395hh does not confer retroactive rulemaking authority on the Secretary. *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 213-214 & n.3 (1988).

2. Had Congress intended the Secretary's construction, it would have worded the statute differently and addressed numerous problems created by that construction.

The only words in the GME statute relating to the numerator of the base year amount per resident determination are "amount recognized as reasonable under this subchapter for direct graduate medical education costs" "for the hospital's cost reporting period that began during fiscal year 1984." 42 U.S.C. § 1395ww(h)(2)(A). In terms, these words do not delegate authority to the Secretary. Nonetheless, based on these words, the Secretary has taken extraordinary actions that significantly affect not only GME payments but also payments for operating costs under PPS.

The Secretary effectively revoked the reopening and record retention standards applicable to 1984 after those standards had already expired. She directed the Medicare intermediaries to conduct a reaudit that has produced an amount for the numerator used to determine the base year average that in many instances differs significantly from the amount actually recognized as reasonable for 1984. 42 C.F.R. § 413.86(e)(1)(iii). She furnished instructions to the intermediaries regarding substitution of data from other years where data is no longer available for 1984. 55 Fed. Reg. 36,063-64 (1990). She revoked the consistency rule in effect in 1984 for purposes of the GME reaudit of 1984. 42 C.F.R. §§ 412.113(b)(3), 413.86(e)(1)(ii)(B)-(C); 54 Fed. Reg. 40,315-17, J.A. 26, 29-30. She significantly modified the principles in her PPS regulations regarding the finality of the PPS hospital-specific rate. 42 C.F.R. § 405.477(c)(2) (1983); 42 C.F.R. § 413.86(j); 54 Fed. Reg. 40,318-19, J.A. 36-38. She retroactively authorized, under certain circumstances, adjustments to the PPS hospital-specific rate for PPS transition years, even though all those years had been completed when she issued the reaudit regulations, but she declined

to authorize corresponding adjustments to the PPS federal rate. 54 Fed. Reg. 40,301 (1989).

In applying the first step of *Chevron*, courts may not assume that the statutory language is "imprecise" but must assume instead that "Congress said what it meant." *United States v. LaBonte*, 117 S. Ct. at 1677. The GME statute says nothing about a special reaudit or changing reimbursement standards or revoking limitation periods or amending payments under PPS. It simply directs the Secretary to determine an average, the numerator of which would be established under the existing administrative process in the Medicare statute. Both the *Toledo* court and the *Tulane* district court correctly noted that had Congress intended the Secretary's construction, it would have worded the statute quite differently. *Toledo*, Pet. App. 33a-34a; *Methodist Hospitals of Memphis v. Sullivan*, 799 F. Supp. at 1218. To accept the Secretary's construction, the Court would have to assume that Congress spoke with incredible imprecision and said the exact opposite of what it meant.

In *EEOC v. Arabian American Oil Co.*, 499 U.S. 244, 255-56 (1991), this Court rejected the EEOC's view that Title VII of the Civil Rights Act applies overseas because, among other things, Congress did not address in the Act issues (*e.g.*, overseas enforcement mechanisms and conflicts with foreign laws and procedures) that it almost certainly would have addressed if it had intended the agency's construction. That same logic requires rejection of the Secretary's construction here.

If Congress had intended for the Secretary to conduct a special reaudit of 1984 costs after expiration of the reopening period established under the Medicare subchapter, it undoubtedly would have addressed many issues, including the following:

(1) the period during which the special reaudit was to be conducted;

(2) the procedures to be used for the reaudit;

(3) the evidentiary problems created by conducting a special reaudit after expiration of reopening and document retention periods;

(4) whether data from a year other than 1984 could be used for the 1984 reaudit and, if so, under what circumstances;

(5) whether the Secretary could depart from the reimbursement principles in effect in 1984 and, if so, to what extent;

(6) whether the Secretary could make reclassifications of costs in the reaudit inconsistent with the classifications used for the PPS hospital-specific rates and federal rates; and

(7) if the Secretary were allowed to depart from the PPS classifications for purposes of the GME reaudit, whether she had to make conforming reclassifications under PPS and, if so, to what extent and how.

Although the GME legislation reflects a close attention to detail, it is silent with respect to all of the issues addressed in the preceding paragraph. That is not surprising under a plain meaning construction of § 1395ww (h)(2)(A) because a plain meaning construction avoids all those issues. However, the Secretary's construction requires that all the identified issues be addressed. The fact that Congress did not do so—indeed, the fact that Congress was completely silent on all these weighty matters—furnishes persuasive evidence that the agency's construction departs radically from Congress' intent.[9]

[9] The legislative history is also silent on these matters. The fact that the legislative history does not address any of the matters or furnish any support for the extraordinary actions taken by the Secretary in the reaudit regulations further demonstrates the error of the Secretary's construction. *See Connecticut National Bank v. Germain*, 503 U.S. 249, 255 (1992) (Stevens, J., concurring) ("If Congress had intended such a significant change . . ., some indica-

3. *The Secretary's construction of the words "amount recognized as reasonable under this subchapter" in 42 U.S.C. § 1395ww(h)(2)(A) conflicts with her construction, and the courts' construction, of nearly identical language in other sections of the Medicare subchapter.*

As addressed above, an analysis of 42 U.S.C. § 1395ww (h)(2)(A) in the context of other provisions in § 1395ww(h) plainly supports petitioner's "plain meaning" construction and rebuts the Secretary's "activist" construction. A review of the statutory provision in the broader context of other subsections of 42 U.S.C. § 1395ww does so as well.

The basic concept in § 1395ww(h)(2)(A) of using an amount recognized as reasonable in a base year for future payment purposes parallels other provisions of § 1395ww enacted just a few years earlier. In the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), Congress enacted two such limits applicable to cost reimbursement.[10] Pub. L. No. 97-248, § 101(a)(1). In neither case did the Secretary conduct a special reaudit of the designated base year to determine the amount of the limit. In both cases, the Secretary used the final determination of allowable costs established under the normal audit and review process for the base year itself in determining the amount of the limit.[11]

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tion of this purpose would almost certainly have found its way into the legislative history").

[10] For one of these, Congress specified that the limit "shall in no event be lower than the allowable operating costs of inpatient hospital services . . . *recognized under this subchapter* for such hospital's [base year]." 42 U.S.C. § 1395ww(a)(1)(C) (emphasis added). The other limit (denoted the "target amount") was defined in terms of "the allowable operating costs of inpatient hospital services . . . *recognized under this subchapter* for such hospital for [the base year]." 42 U.S.C. § 1395ww(b)(3)(A)(i) (emphasis added).

[11] Although the TEFRA provisions were more complex than the GME legislation, the Secretary issued extensive implementing regulations on September 30, 1982, less than one month after the President signed the TEFRA legislation. *See* 47 Fed. Reg. 43,281-43,338 (1982).

In 1983, Congress incorporated the "target amount" into PPS, again using a hospital's allowable operating costs "recognized under this subchapter" for a base year to determine future reimbursement (the PPS "hospital-specific rate"). Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e); 42 U.S.C. §§ 1395ww (d)(1)(A)(i)(I), (ii)(I) (incorporating 42 U.S.C. § 1395ww(b)(3)(A)). The Secretary did not reaudit the base year costs to be used for future years,[12] but she issued a regulation that permitted the use of two different base year amounts in limited circumstances.[13] That regulation was invalidated in *Georgetown II*, which required uniformity in the base year amounts. The court concluded that costs that were "recognized under this subchapter" in a final administrative decision for the base year had to be recognized in the base year amount used for the PPS hospital-specific rate. 862 F.2d at 327. The Secretary subsequently issued a nationwide ruling acquiescing in the court decision. *See* Health Care Financing Administration Ruling 89-1, [1989 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 37,614 (1989), District Court Docket Item 14 (Exhibit 1).

In other provisions of § 1395ww, statutory references to amounts "recognized under this subchapter" for base years have been construed by the Secretary and the courts to mean the amounts actually recognized in the final

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[12] Although PPS was far more complex than the GME legislation, the Secretary issued implementing regulations on September 1, 1983, a little more than four months after the President signed the PPS legislation. *See* 48 Fed. Reg. 39,752-39,890 (1983).

[13] The Secretary used the base year (1982) NPR to establish the PPS hospital-specific rate, but in most instances she declined to adjust the hospital-specific rate to reflect subsequent adjustments to the 1982 NPR resulting from reopenings, administrative decisions, and judicial decisions.

determinations established through the normal audit and review process for the base years themselves.[14] Only in this instance has the Secretary sought to conduct an extraordinary reaudit to establish a new base year amount to be used to set rates for subsequent years.[15] Thus, the Secretary's regulation conflicts with the " 'normal rule of statutory construction' that 'identical words used in different parts of the same act are intended to have the same meaning.' " *Sullivan v. Stroop*, 496 U.S. 478, 484 (1990), *quoting Sorenson v. Secretary of Treasury*, 475 U.S. 851, 860 (1986); *see also Patterson v. Shumate*, 504 U.S. 753, 766 (1992) (Scalia, J., concurring) ("consistency of usage within the same statute is to be presumed").

C. The Absence of an Express Prohibition Barring a Special Reaudit of GME Costs After Expiration of Applicable Limitation and Document Retention Periods Does Not Create Ambiguity.

It is of course true that Congress did not *expressly* prohibit the Secretary from reauditing 1984 GME costs

[14] The TEFRA and PPS limits and rates also required the Secretary to determine an "average." The average was computed on a "per [patient] admission or per [patient] discharge basis." 42 U.S.C. § 1395ww(a)(4).

In the preamble to the reaudit regulations, the Secretary noted that, in enacting the GME legislation, "Congress provided . . . for a hospital-specific payment [for GME] that may be characterized as similar to the hospital-specific rate used in the prospective payment system." 54 Fed. Reg. 40,309 (1989). The *Tulane* district court concluded that "the principles of interpretation" for the two provisions (42 U.S.C. §§ 1395ww(b)(3)(A) and 1395ww(h)(2)(A)) are "the same." *Methodist Hospitals of Memphis v. Sullivan*, 799 F.Supp. at 1217.

[15] The 1984 base year selected for the GME amount per resident methodology is the same base year that the Secretary had previously selected for her freeze on increases in medical education costs. 42 C.F.R. § 405.421(a)(2)(i) (1985); 50 Fed. Reg. 27,732 (1985). The Secretary made clear when she adopted the freeze that the final GME cost determination for 1984 would also be used for purposes of the freeze. 50 Reg. 27,722, 27,726 (1985).

after expiration of the 1984 reopening and record retention periods and from using the reaudited amount for the GME amount per resident methodology. But, then, Congress could hardly be expected to expressly prohibit conduct that it could not possibly have anticipated and that conflicts with its express command. Thus, the Sixth Circuit in *Toledo* was correct in concluding that a court may not "presume a delegation of interstitial rulemaking authority when the claimed ambiguity in the statute stems not from the use of a word with several plausible interpretations, nor from the statute's lack of specificity regarding mundane procedural issues, but from nothing more than the failure of Congress to proscribe explicitly an unusual procedure which may be plainly at odds with the result Congress was trying to reach." Pet. App. 29a.

In *Tulane*, the D.C. Circuit did just that, finding ambiguity in the fact that Congress did not expressly prohibit her from abandoning the established administrative process and reopening final and binding determinations made under that process. *See* Pet. App. 46a. Since *Tulane*, however, the D.C. Circuit has followed an approach under *Chevron* step one that is entirely consistent with the one taken by the Sixth Circuit in *Toledo* and faithful to this Court's precedents. Thus, in rejecting a construction of the National Mediation Board, the D.C. Circuit, in an *en banc* decision authored by now Chief Judge Edwards, said:

> To suggest, as the Board effectively does, that *Chevron* step two is implicated any time a statute does not expressly *negate* the existence of a claimed administrative power (*i.e.* when the statute is not written in "thou shalt not" terms), is both flatly unfaithful to the principles of administrative law outlined above, and refuted by precedent. . . . Were courts to *presume* a delegation of power absent an express *withholding* of such power, agencies would enjoy virtually limitless hegemony, a result plainly out of keeping with *Chevron* and quite likely with the Constitution as well.

Railway Labor Executives' Ass'n v. National Mediation Board, 29 F.3d 655, 671 (D.C. Cir. 1994) (*en banc*), *cert. denied*, 115 S. Ct. 1392 (1995) (original emphasis); *see also Backcountry Against Dumps v. EPA*, 100 F.3d 147, 151 (D.C. Cir. 1996); *American Petroleum Inst. v. U.S. EPA*, 52 F.3d 1113, 1120 (D.C. Cir. 1995); *Ethyl Corp. v. EPA*, 51 F.3d 1053, 1060 (D.C. Cir. 1995). That approach faithfully follows the course set by this Court. *See, e.g., Adams Fruit Co., Inc. v. Barrett*, 494 U.S. 638, 650 (1990) ("[I]t is fundamental 'that an agency may not bootstrap itself into an area in which it has no jurisdiction.' "); *Board of Governors of Fed. Res. Sys. v. Dimension Financial Corp.*, 474 U.S. at 374 ("The statute may be imperfect, but the board has no power to correct flaws that it perceives in the statute it is empowered to administer").

* * * *

The Secretary's reaudit regulation conflicts with the plain meaning of 42 U.S.C. § 1395ww(h)(2)(A). "When the words of a statute are unambiguous, then . . . 'judicial inquiry is complete.' " *Connecticut National Bank v. Germain*, 503 U.S. at 254. Thus, in this case, the first step of *Chevron* is also the last.[16]

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[16] In her brief responding to petitioner's petition for certiorari (at 10-11), the Secretary erroneously suggests, for the first time in this case, that a provision in the Omnibus Budget Reconciliation Act of 1990 ("OBRA 1990"), Pub. L. No. 101-508, reflects Congress' approval of the Secretary's reaudit regulations. The 1990 statute, which makes no reference to the Secretary's regulations, provides that the Secretary "may not, before October 1, 1991, recoup payments from a hospital because of alleged overpayments to such hospital under part A of title XVIII of the Social Security Act due to a determination that the amount of payments made for graduate medical education programs exceeds the amount allowable under [42 U.S.C. § 1395ww(h)]." OBRA 1990, § 4004(a)(1). It also provides that recoupments be gradually phased in over a four-year period. *Id.* § 4004(a)(2).

The 1990 legislation was enacted because by 1990 the Secretary had failed to apply § 1395ww(h) to *any* hospital for *any* cost reporting year. Instead, even though "reasonable cost" principles were inapplicable to fiscal years beginning on or after July 1, 1985, the Secretary had continued, from 1986 onward, to settle those years under "reasonable cost" principles. Thus, recoupment was required for those years to effectuate § 1395ww(h), irrespective of the question at issue in this case. The 1990 legislation ensured that the recoupment would occur gradually over a substantial period of time, thus avoiding the severe cash flow problems that recoupment might otherwise cause.

The 1990 legislation expresses no opinion regarding the merits of the Secretary's base year amount per resident determinations. Indeed, it could not possibly have done so because, at the time, the Secretary had not yet made the determinations. The nonjudgmental nature of Congress' action is evident from its reference to the recoupment of *"alleged* overpayments." OBRA 1990, § 4004(a)(1) (emphasis added). Thus, the Secretary's belated reliance on the 1990 legislation is misplaced.

II. EVEN ASSUMING ARGUENDO AN AMBIGUITY IN THE STATUTORY LANGUAGE, THE REAUDIT REGULATION ADOPTS A PATENTLY UNREASONABLE CONSTRUCTION.

An agency construction of an ambiguous statutory provision is not necessarily valid under *Chevron*. To be valid under *Chevron* step two, the agency's construction must be "reasonable." 467 U.S. at 844.

The reaudit regulation is patently unreasonable in numerous respects. It conflicts with the principle of issue preclusion and with principles of fundamental fairness. It is based on absurd assumptions. It creates irrational inconsistencies with the GME base year determination and with the cost classifications underpinning the entire PPS payment methodology. Thus, even if the reaudit regulation could pass *Chevron* step one, it would still fail *Chevron* step two.

A. The Reaudit Regulation Conflicts With the Principle of Issue Preclusion and With Principles of Fundamental Fairness.

The reaudit regulation set aside, in many cases, determinations that were already "final and binding." 42

C.F.R. § 405.1807. Those determinations were made shortly after the close of the 1984 year. The hospitals had proven their claims in formal on-site audits at a time when there were few evidentiary problems—documentation was still readily available, personnel had personal knowledge of 1984 events, and memories were still sharp.

The reaudit regulation set aside these "final and binding" determinations at a time when hospitals could no longer reasonably be expected to reprove their claims. Hospitals had previously received notice through the Secretary's regulations that 1984 physician allocation agreements and time studies could be discarded. 42 C.F.R. § 405.481(g)(3) (1985). Hospitals had also previously received notice through the Secretary's regulations that "findings on matters at issue" in the determination for 1984 were final and no longer subject to reopening. 42 C.F.R. § 405.1885(a) (1985). In many cases, key personnel had left, with positions often having turned over several times since 1984. If still at the hospital, their recollection of events in 1984 was generally dim, at best. Nonetheless, the reaudit regulation imposed on hospitals the obligation to reprove claims that they had already proven with finality several years earlier.

The reaudit regulation, therefore, conflicts with the principle of issue preclusion. A formal determination had already been made with respect to the amount recognized as reasonable under the Medicare statute for 1984 and that determination and "findings on matters at issue" therein were no longer subject to reopening. 42 C.F.R. § 405.1885(a). Res judicata and collateral estoppel apply to final administrative determinations so long as there was an adequate opportunity to contest the issue in the original determination, as there clearly was here. *United States v. Utah Construction & Mining Co.*, 384 U.S. 394, 422 (1966); *Draper v. Sullivan*, 899 F.2d 1127, 1130-31 (11th Cir. 1990). It is irrational to assume that Congress intended the Secretary to retroactively revoke her own reopening standards. As the *Toledo* court concluded, "the principle of issue preclusion prevents the Secretary from requiring providers to re-establish the costs that they already proved years ago." Pet. App. 36a.

Parties are of course entitled to question and contest the validity of a determination so long as it is subject to further review or reopening. Once final, however, a determination is presumed correct. *See Medical Arts Building Ltd. v. Eralp*, 290 N.W.2d 241, 246 (N.D. 1980) ("The words 'final' and 'conclusive' . . . mean that the matter decided is irrefutable and admits of no explanation of contradiction"). *Finality brings repose.* Indeed, the very notion of "redetermining" a determination that is "final and binding" is an oxymoron.

The Medicare three-year reopening period is the functional equivalent of a statute of limitations. *See Pellham Bay General Hospital v. Schweiker*, [1984-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 33,468 at 9360 & n.9 (D.D.C. 1983). Statutes of limitations:

> are not simply technicalities. . . . [T]here comes a point at which the delay of a plaintiff in asserting a claim is sufficiently likely either to impair the accuracy of the fact-finding process or to upset settled expectations that a substantive claim will be barred without respect to whether it is meritorious.

Board of Regents of the University of the State of New York v. Tomanio, 446 U.S. 478, 487 (1980). Statutes of limitations:

> represent a pervasive legislative judgment that it is unjust to fail to put the adversary on notice to defend within a specified period of time and that "the right to be free of stale claims in time comes to prevail over the right to prosecute them." . . . These enactments are statutes of repose; . . . they protect defendants and the courts from having to deal with cases in which the search for truth may be seriously impaired by the loss of evidence, whether by death

> or disappearance of witnesses, fading memories, disappearance of documents, or otherwise.

United States v. Kubrick, 444 U.S. 111, 117 (1979) (citations omitted).

The Medicare reopening standards were intended to ensure, not impede, accuracy. The reaudit regulation allows exactly what the reopening standards were designed to prevent—the impairment of the "accuracy of the fact-finding process" and the "unjust" treatment of hospitals that had already been put on notice that the determination of 1984 costs was final and binding. It is not credible that a 1991 audit of 1984, conducted two years after that year was closed under long-established Medicare principles, would yield more accurate results than did the 1986 audit of 1984.

It is well-established that "[j]ust determinations of fact cannot be made when, because of the passage of time, the memories of witnesses have faded or evidence is lost." *Wilson v. Garcia*, 471 U.S. 261, 271 (1985). It is equally well-established that a "fundamental requirement of due process is 'the opportunity to be heard' . . . at a meaningful time and in a meaningful manner," *Armstrong v. Manzo*, 380 U.S. 545, 552 (1965), which obviously would not be the case if the action is not even initiated until after the expiration of the limitations period. Indeed, as this Court has recently recog ized, "extending a statute of limitations after the pre-existing period of limitations has expired impermissibly revives a moribund cause of action." *Hughes Aircraft Co. v. United States*, 65 U.S.L.W. at 4450. Moreover, construing a statute to lengthen a limitations period "conflicts with a basic objective—repose—that underlies limitations periods." *Klehr v. A.O. Smith Corp.*, 65 U.S.L.W. 4514, 4517 (1997). The reaudit regulation runs afoul of these bedrock principles. Thus, the Sixth Circuit was correct in finding that the Secretary "ignored . . . the basic fairness issues implicated." *Toledo*, Pet. App. 37a.

Significantly, in stark contrast with her position in this case, the Secretary has strongly defended the strict application of Medicare finality principles in the past, contending that finality outweighs interests in accuracy. For instance, when the Secretary acknowledged in 1986 that her 1979 regulation governing the apportionment of malpractice insurance costs was invalid, she relied on the principle of administrative finality to justify not making corrections to closed years, including PPS base years, stating:

> [T]he general importance of ensuring the finality of decisions on reimbursement issues outweighs whatever benefits might be received by providers whose malpractice insurance costs are outside the reopening period. Our rules of administrative finality and reopening protect both the Medicare Trust Funds and the provider community from unexpected contingencies that might arise long after a decision becomes final. . . . *Regardless of whether our finality and reopening rules benefit or disadvantage providers in a specific case, their overall role of providing certainty in the administrative process is important enough to warrant their consistent application.*

51 Fed. Reg. 11,187 (1986) (emphasis added). The reaudit regulation is hardly in keeping with the Secretary's stated commitment to "consistent application" of the Medicare "finality and reopening" standards.

Ironically, when a reopening would work to her disadvantage, the Secretary often refuses to reopen even during the three-year reopening period. For instance, after the Secretary's construction of the statute governing the Medicare adjustment for hospitals that serve a disproportionate share of low-income patients was struck down by all four courts of appeals to address the matter, the Secretary recently issued a ruling acquiescing in the construction mandated by the court decisions. Health Care Financing Administration Ruling 97-2, [1997 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 45,105 (1997). However, the ruling expressly states that "[w]e

will not reopen settled cost reports based on this issue," even though those reports had been settled under a clearly invalid policy. *Id.* at 53,000.

Similarly, after this Court invalidated the Medicare retroactive wage index rule in *Bowen v. Georgetown Univ. Hosp.*, the Secretary issued a ruling conceding defeat with respect to the retroactive wage index rule, the related retroactive malpractice rule, and, as noted above, the PPS issue in *Georgetown II*. Health Care Financing Administration Ruling 89-1, [1989 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 37,614 (1989), District Court Docket Item 14 (Exhibit 1). However, the ruling did not provide for any reopenings and allowed the intermediaries to apply the Secretary's concessions only to "pending" appeals. *Id.*; *Tucson Medical Center v. Sullivan*, 947 F.2d 971, 978, 982 (D.C. Cir. 1991). There is a fundamental inconsistency in the Secretary's refusal to reopen cost reports still within the three-year reopening period to correct underpayments resulting from the application of a policy unanimously struck down by this Court, but insisting on reopening cost reports after expiration of the three-year reopening period to conduct a reaudit of GME costs for 1984.

B. The Reaudit Regulation Is Based on Flawed and Unreasonable Assumptions.

The reaudit regulation is also unreasonable because it is based on several irrational assumptions.

First, the Secretary apparently assumed that she was free to defer implementation of the GME payment methodology as long as she liked. Even though the GME legislation made "reasonable cost" payment principles inapplicable to GME for cost reporting years beginning on or after July 1, 1985, the Secretary continued, for the five year period 1986-1991, to settle GME costs under "reasonable cost" principles because she had not determined the base year amounts per resident necessary to effectuate

the GME statute. It was not until 1991 that she began applying the GME payment methodology to recoup payments made under the "reasonable cost" payment methodology.

Congress made the GME payment methodology effective for cost reporting years beginning on or after July 1, 1985. Pub. L. No. 99-272, § 9202(b). Absolutely nothing in the legislation suggests that Congress intended that implementation of the statute be deferred or that the Secretary continue to use "reasonable cost" principles for years beginning on or after July 1, 1985. Since Congress clearly intended immediate implementation, it follows that Congress intended the Secretary to use the base year audit determination for 1984 to establish the base year amount for the amount per resident methodology.

Second, the Secretary erred in her belief that a reaudit was necessary for 1984. The original determinations were *audited* figures. The original audits were performed shortly after the close of the 1984 year, when audit documentation was still readily available, when memories were still fresh, and when hospital and intermediary personnel had not substantially turned over. The passage of time did not improve the reliability of evidence. A 1991 reaudit posed enormous evidentiary and due proces problems that did not exist for the 1986 audit.[17]

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[17] By 1984, the Medicare intermediaries had been conducting audits under "reasonable cost" principles for nearly twenty years. Thus, they were experienced in auditing GME costs. Moreover, the Medicare intermediaries were able to devote their full attention to GME costs for the year serving as the GME base year. Since that year was also the first year under the new PPS for operating costs, the Medicare intermediaries were no longer required to audit operating costs (which account for approximately 80% of all hospital costs) under "reasonable cost" principles, thus allowing them much greater time than in the past to audit GME costs. *See, e.g.*, Comments of University of Michigan Medical Center at 4, District Court Docket Item 14 (Exhibit 2). Indeed, they had special reason to be careful because, under the Secretary's 1985 regulation, their

Even more fundamentally, a "plain meaning" construction of the statute would not have prevented the Secretary from correcting any errors that might have existed. When the GME statute was enacted, no final and binding determinations of reasonable GME costs had yet been made for 1984. Thus, as the *Tulane* district court correctly observed, "[a]ny concern the Secretary might have had about the accuracy of those figures could have been addressed within the standard three-year period. . . ." *Methodist Hospitals of Memphis,* 799 F. Supp. at 1218; *see also Toledo,* Pet. App. 36a ("Had the Secretary acted promptly, there would have been no need to revisit any closed determinations, because all of the 1984 numbers were still subject to reopening for some time after the passage of the GME amendment").

Finally, the Secretary apparently proceeded on the assumption that there were no time constraints on her ability to reexamine 1984 costs. 54 Fed. Reg. 40,302 (1989). Because she believed that there may have been inaccuracies in the original audit, she decided in 1989 to conduct a reaudit of 1984, even though in many cases the 1984 year was closed. By that logic, if she decided today that

audit determination was to be used not only for 1984 reimbursement but also for the 1985 freeze.

The Secretary's assertion that amounts per resident derived from the base year audits varied from less than $10,000 to more than $100,000 proves nothing. The Secretary's reaudit determinations also resulted in such variation. *See* District Court Docket Item 14 (Exhibits 3 and 4). The variation in amounts is not surprising both because of the great variation in the sophistication and scope of GME programs and because of the methodology used to compute GME amounts per resident. A hospital's base year allowable costs (the numerator) included the costs which the hospital incurred in compensating its residents on rotation at other hospitals, but its resident count (the denominator) included only the number of residents physically located on its premises. 55 Fed. Reg. 36,064-65 (1990). Thus, hospitals that rotated residents to other hospitals necessarily had a large amount per resident, while the recipient hospitals had a relatively small amount per resident.

there may have been inaccuracies in her 1991 reaudit, she could conduct another reaudit of 1984 costs in 1998—and presumably could do so again in the year 2003, if she chose. The logic of the Secretary's position would potentially subject hospitals to a perpetual series of reaudits of 1984 costs, thus precluding the possibility of ever reaching a point of repose.

C. The Reaudit Regulation Creates Inconsistencies With the Base Year Determination and With the Cost Classifications Underlying the Prospective Payment System.

The reaudit regulation results in inconsistent determinations for the base year. The original audit established the amount actually applied to 1984. The reaudit establishes a different 1984 amount that is used for the amount per resident methodology.[18] An agency may not rationally apply the same principles to the same provider for the same period of time (1984) to reach two equally valid but different determinations of allowable costs. *See Methodist Hospitals of Memphis,* 799 F.Supp. at 1218 ("Congress could not have intended that the Secretary interpret 'recognized as reasonable' to mean two amounts for fiscal 1984"). If the first determination is final and valid (as the Secretary concedes it is), the later, inconsistent determination must necessarily be invalid. *See, e.g., American Federation of Government Employees, AFL-CIO, Local 3090 v. FLRA,* 777 F.2d 751, 760 (D.C. Cir. 1985) (Scalia, J., concurring) ("I do not think it to be true . . . that an agency is free to take inconsistent positions. . . . It is the agency's responsibility to behave in a rational (and hence reasonably consistent) fashion").

The reaudit regulation also creates inconsistency with the cost classifications that were established in the PPS

[18] The reaudit was also often based on different data than the data used for the original audit. The original audit of 1984 was based on 1984 data. However, because of the expiration of the document retention period for 1984, the reaudit of "1984" often was based in substantial part on data for a later year. 55 Fed. Reg. 36,063-64 (1990).

rates. When the Secretary issued the PPS regulations in 1983, she recognized the importance of consistently treating allowable costs as either operating or education through the consistency rule, which provided that "the costs of medical education must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion" of the PPS payment. 42 C.F.R. § 405.477(c)(2) (1983); 42 C.F.R. § 412.113(b) (1985). Thus, an allowable cost that was determined to be an operating cost in the PPS base year (1982) could not be reclassified as an education cost during 1984, and an allowable cost that was determined to be an education cost in the PPS base year could not be reclassified as an operating cost in 1984. The cost classifications established in the audit and appeals process for the PPS base year were to have binding effect for 1984. In addition, the Secretary's PPS hospital-specific rate regulations specified that the hospital-specific rate is "final, and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983" except in very limited circumstances not encompassed by the GME reaudit. 42 C.F.R. § 405.474(b)(1)(v) (1983); 42 C.F.R. § 412.71(d) (1985).

When the Secretary issued the reaudit regulations in 1989, she retroactively repealed the consistency rule for purposes of the 1984 reaudit. 42 C.F.R. § 412.113(b)(3). Consequently, during the reaudits, intermediaries frequently reclassified GME costs as operating costs for the GME base year (1984) even though the costs had been determined to be education costs in the PPS base year (1982) and thus were excluded from allowable operating costs for purposes of establishing the PPS federal rate and the PPS hospital-specific rate. 42 C.F.R. § 413.86(e)(1)(ii)(B)-(C). This of course created inconsistencies with the cost classifications used to establish the PPS rates.

The Secretary purported to deal with the inconsistency by allowing hospitals to request an adjustment to their PPS hospital-specific rates for PPS transition years (1984-

1987) still within the three-year reopening period to reflect reclassifications of costs in the GME reaudit. 42 C.F.R. § 413.86(j)(1)(i). But this failed to solve the problem of inconsistency. Under the Secretary's view, to qualify for the adjustment to the PPS hospital-specific rate, hospitals had to furnish documentation from their PPS base year (1982), 42 C.F.R. § 413.86(j)(1)(ii), which was often impossible because by the date of the GME reaudit determination (1991), the reopening and record-retention periods for 1982 had long since passed. *See Harrisburg Hosp. v. Blue Cross and Blue Shield Ass'n*, [1996 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 44,419 (HCFA Adm'r Dec.) (1996).

Even more significantly, the Secretary ensured enormous inconsistency by refusing to make any adjustment to the federal rate (which since 1988 has constituted 100% of the PPS payment) to reflect the reclassification of costs from education to operating in the GME reaudits. 54 Fed. Reg. 40,301 (1989). As a consequence, the reclassification of costs from education to operating in the GME reaudits has meant not that hospitals would be reimbursed for the costs as operating costs, but that they would receive no reimbursement for these costs (either as GME or as operating costs) even though the costs were clearly allowable Medicare costs. Thus, the Secretary's reaudit regulation overturns the principle of consistency upon which PPS was based and results in the conversion of clearly allowable costs into non-allowable costs. Absolutely nothing suggests that when Congress enacted the GME legislation it had any such intent.[19]

The reaudit regulation is an unreasonable construction of the GME statute, one that conflicts with collateral estoppel and principles of fundamental fairness, due process, and finality. Thus, even were *Chevron* applicable

[19] Indeed, the Secretary acknowledged in the preamble to the reaudit regulation that "[t]here is nothing in [the GME legislation] that addresses the recomputation of HSRs [PPS hospital-specific rates]." 54 Fed. Reg. 40,301 (1989).

and even were the GME statute ambiguous, the reaudit regulation would nonetheless fail under *Chevron* step two, as the Sixth Circuit expressly held in *Toledo*. Pet. App. 34a-37a.

III. THE REAUDIT REGULATION CONSTITUTES AN IMPERMISSIBLE RETROACTIVE CONSTRUCTION OF THE GME STATUTE.

As discussed in the preceding two sections, the Secretary's reaudit regulation fails under *Chevron*. To prevail in this case, however, the Secretary must satisfy a far more exacting standard than *Chevron*. Because of the retroactive effect of the Secretary's construction, the correct standard of review is established not by *Chevron* but by *Bowen v. Georgetown Univ. Hosp.* and *Landgraf v. USI Film Products*.

In *Georgetown* (a case, like this, involving the validity of a Medicare regulation), the Court unanimously held that an agency must possess an express grant of retroactive rulemaking authority to issue a retroactive rule. 488 U.S. at 208. In *Landgraf*, the Court reaffirmed the long-standing presumption against retroactive legislation. 114 S. Ct. at 1501, 1505. The Court applies "this time-honored presumption unless Congress has clearly manifested its intent to the contrary." *Hughes Aircraft Co. v. United States*, 65 U.S.L.W. at 4449.

The reaudit regulation has some extraordinary consequences. For purposes of the GME reaudit, the reaudit regulation effectively revoked in 1989 the reopening and record retention periods applicable to 1984, after both had expired, and repealed the consistency rule in effect in 1984. It also authorized in 1989 adjustments to the PPS hospital-specific rate for fiscal years 1984-1987, even though the regulation in effect in 1984 specified that the hospital-specific rates were "final."

The GME statute clearly did not command the Secretary to take these actions. Nor did the GME statute confer any express delegation that would authorize the Secretary to take these actions on her own initiative.

Thus, if the reaudit regulation is retroactive, it is invalid under *Georgetown* and *Landgraf*, irrespective of whether it would otherwise pass muster under *Chevron*.

The Secretary argues that the reaudit regulation is not retroactive because it adds no retroactivity not inherent in the statute itself. Brief of Defendant Appellee at 22-23. The *Tulane* court concluded that the reaudit regulation is not retroactive because the "reaudit carries no impact for actual 1984 reinmbursements and will be used only to calculate future reimbursements." Pet. App. 52a. Neither view bears analysis.

Petitioner acknowledges that there is some retroactivity inherent in the statute and does not challenge the retroactivity mandated by Congress. Congress obviously intended to replace "reasonable cost" reimbursement with a new GME payment methodology, effective for cost reporting years beginning on or after July 1, 1985. Congress also clearly intended that payment under the GME methodology would be based on the average amount recognized as reasonable per FTE resident for 1984. That provision, while involving secondary retroactivity for "future" years, does not mandate any primary retroactivity for 1984 because, when the GME statute was enacted, a long-standing process was already established under the Medicare subchapter to determine the amount recognized as reasonable for 1984.

The Secretary's regulation goes much further. It imposes a significant *new* burden on 1984 conduct. It retroactively subjected 1984 to a reaudit, after the reopening and record retention periods applicable to 1984 had expired, and retroactively reversed reimbursement principles in effect in 1984. This is most assuredly *not* retroactivity mandated by the statute.

The *Tulane* court is of course correct in stating that the 1984 reaudit affects reimbursement only for years after 1984, not reimbursement for 1984 itself. It does not follow therefrom, however, that the reaudit regulation is not retroactive. The reaudit mandated by the regulation is a reaudit of *1984* conduct, not a reaudit of 1987 or

1989 or 1992 conduct. The principle underlying the *Landgraf* presumption is that "the legal effect of conduct should ordinarily be assessed under the law that existed when the conduct took place." *Landgraf*, 114 S. Ct. at 1497, *quoting Kaiser Aluminum & Chemical Corp. v. Bonjorno*, 494 U.S. 827, 855 (1990) (Scalia, J., concurring). The "conduct" here took place in 1984.

In *Landgraf*, the Court noted that "retroactivity is a matter on which judges tend to have 'sound . . . instinct[s],' . . . and familiar considerations of fair notice, reasonable reliance, and settled expectations offer sound guidance." 114 S. Ct. at 1499 (citation omitted). Application of these principles leads inexorably to the conclusion that 1984 is the proper reference point for determining whether the 1989 reaudit regulation is retroactive.

As discussed above, a limitations period serves several purposes. It protects "settled expectations" and ensures "the accuracy of the fact-finding process." *Board of Regents of the University of the State of New York v. Tomanio*, 446 U.S. at 487. It also provides "notice" of the maximum period of potential liability, promotes "repose," and protects parties "and the courts from having to deal with cases in which the search for truth may be seriously impaired by the loss of evidence, whether by death or disappearance of witnesses, fading memories, disappearance of documents, or otherwise." *United States v. Kubrick*, 444 U.S. at 117. "Just determinations of fact cannot be made when, because of the passage of time, the memories of witnesses have faded or evidence is lost." *Wilson v. Garcia*, 471 U.S. at 271.

Any revocation of the reopening and record retention periods applicable to 1984 *after* those periods have already expired defeats these well-established purposes—irrespective of the purpose of the reaudits. Applying the 1984 reaudit results to determine Medicare payments for 1990, instead of Medicare payments for 1984, does not in any way lessen the injustice of failing to provide clear and timely notice to a hospital that has already proven its claims for 1984 in a "final and binding" determination, 42

C.F.R. § 405.1807, that the determination is not, in fact, "final and binding" and that the hospital must once again prove its 1984 claims after the 1984 limitations period has expired. Nor does the fact that the 1984 reaudit results are not applied directly to amend 1984 reimbursement in any way ameliorate the difficulties of dealing with "cases in which the search for truth may be seriously impaired by the loss of evidence," *United States v. Kubrick*, 444 U.S. at 117, or prevent the denial of basic due proces rights caused by the failure to ensure " 'the opportunity to be heard' . . . at a meaningful time and in a meaningful manner," *Armstrong v. Manzo*, 380 U.S. at 552.

The Court's recent decision in *Hughes Aircraft Co. v. United States* clearly supports petitioner's position. At issue in *Hughes* was a 1986 statutory amendment that removed, in certain circumstances, the bar preventing a *qui tam* relator from filing suit for a false claim if the underlying information was already in the government's possession. The relator in *Hughes* filed suit in 1989, three years after the amendment's enactment, based on an alleged false claim in 1982. Prior to 1986, the relator could not have brought suit because the underlying information was in the government's possession. The relator and the government argued that the determinative event for assessing retroactivity was the filing of suit, which occurred three years *after* the 1986 amendment. This Court, however, disagreed, finding that the proper time reference was 1982, when the false claim was allegedly made. The Court concluded that the relator's suit must be dismissed because of "the absence of a clear statutory expression of congressional intent to apply the 1986 amendment to *conduct completed before its enactment*. . . ." 65 U.S.L.W. at 4451 (emphasis added).

With respect to its conclusion that 1982 furnishes the correct reference point for establishing retroactivity, the Court explained:

> The 1986 amendment would revive [the barred] action, subjecting Hughes to previously foreclosed qui

> tam litigation *much like extending a statute of limitations after the pre-existing period of limitations has expired impermissibly revives a moribund cause of action.* . . . It is simply not the case that . . . the elimination of a prior defense . . . does not "create a new cause of action" or "change the substance of the extant cause of action."

Id. at 4450 (emphasis added). The italicized words, of course, speak directly to the instant case. Here, the reaudit regulation sought to "impermissibly revive[]" an action already barred by principles of administrative finality and an "expired" limitations period. The absence of a clear statement in the statutory language mandating this result requires application of the presumption against retroactivity.[20]

The Secretary has never contended that the GME statute mandates her construction in the reaudit regulation. Rather, her position has always been that the statute is "ambiguous." Brief of Defendant Appellee at 12. Were the statute, in fact, ambiguous, that would be enough for the reaudit regulation to survive scrutiny under *Chevron* step one. But ambiguity is fatal to the Secretary's construction under *Georgetown* and *Landgraf*. The reaudit regulation is retroactive (indeed, extraordinarily so), and thus may be upheld under *Georgetown* and *Landgraf* only if the statute contains a clear statement mandating the Secretary's construction. It does not, as even the Secretary concedes, and thus the reaudit regulation is clearly invalid on retroactivity grounds.

CONCLUSION

For the foregoing reasons, the Court should reverse the judgment below.

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[20] The passage in *Hughes* precluding revival of an expired limitations period absent a clear manifestation of congressional intent to the contrary is fully in accord with *United States v. Zacks*, 375 U.S. 59 (1963). In *Zacks*, the Court ruled that a retroactive change in the tax law favorable to taxpayers did not entitle taxpayers to a refund for closed years because Congress did not expressly reopen closed years to allow taxpayers to take advantage of the retroactive change.

Respectfully submitted,

RONALD N. SUTTER
Counsel of Record
POWERS, PYLES, SUTTER & VERVILLE, P.C.
1875 Eye Street, NW
12th Floor
Washington, DC 20006-5409
(202) 466-6550
Counsel for Petitioner

APPENDIX

APPENDIX

STATUTES AND REGULATIONS INVOLVED

1. 42 U.S.C. § 1395ww(h) provides in relevant part:

(h) Payments for direct graduate medical education costs

(1) Substitution of special payment rules

Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments, the Secretary shall provide for an allocation of such payments between part A and part B of this subchapter (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

(2) Determination of hospital-specific approved FTE resident amounts

The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) Determining allowable average cost per FTE resident in a hospital's base period

The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct

graduate medical education costs of the hospital for each full-time-equivalent resident.

(B) Updating to the first cost reporting period

(i) In general

The Secretary shall update each average amount determined under subparagraph (A) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such subparagraph.

(ii) Exception

The Secretary shall not perform an update under clause (i) in the case of a hospital if the hospital's reporting period, described in subparagraph (A), began on or after July 1, 1984, and before October 1, 1984.

(C) Amount for first cost reporting period

For the first cost reporting period of the hospital beginning on or after July 1, 1985, the approved FTE resident amount for the hospital is equal to the amount determined under subparagraph (B) increased by 1 percent.

(D) Amount for subsequent cost reporting periods

(i) Except as provided in clause (ii), for each subsequent cost reporting period, the approved FTE resident amount for the hospital is equal to the amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer

price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

(ii) For cost reporting periods beginning during fiscal year 1994 or fiscal year 1995, the approved FTE resident amount for a hospital shall not be updated under clause (i) for a resident who is not a primary care resident (as defined in paragraph (5)(H)) or a resident enrolled in an approved medical residency training program in obstetrics and gynecology.

(E) Treatment of certain hospitals

In the case of a hospital that did not have an approved medical residency training program or was not participating in the program under this subchapter for a cost reporting period beginning during fiscal year 1984, the Secretary shall, for the first such period for which it has such a residency training program and is participating under this subchapter, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.

(3) Hospital payment amount per resident

(A) In general

The payment amount, for a hospital cost reporting period beginning on or after July 1, 1985, is equal to the product of—

(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

(ii) the hospital medicare patient load (as defined in subparagraph (C)) for that period.

(B) Aggregate approved amount

As used in subparagraph (A), the term "aggregate approved amount" means, for a hospital cost reporting period, the product of—

(i) the hospital's approved FTE resident amount (determined under paragraph (2)) for that period, and

(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training programs in that period.

(C) Medicare patient load

As used in subparagraph (A), the term "medicare patient load" means, with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A of this subchapter.

(4) Determination of full-time-equivalent residents

(A) Rules

The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

(B) Adjustment for part-year or part-time residents

Such rules shall take into account individuals who serve as residents for only a portion of a

period with a hospital or simultaneously with more than one hospital.

(C) Weighting factors for certain residents

Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

(iv) on or after July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.

(D) Foreign medical graduates required to pass FMGEMS examination

(i) In general

Except as provided in clause (ii), such rules shall provide that, in each case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the individual shall not be counted as a resident on or after July 1, 1986, unless—

(I) the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)), or

(II) the individual has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates.

(ii) Transition for current FMGS

On or after July 1, 1986, but before July 1, 1987, in the case of a foreign medical graduate who—

(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

(E) Counting time spent in outpatient settings

Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(5) Definitions and special rules

As used in this subsection:

(A) Approved medical residency training program

The term "approved medical residency training program" means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.

(B) Consumer price index

The term "consumer price index" refers to the Consumer Price Index for All Urban Consumers (United States city average), as published by the Secretary of Commerce.

(C) Direct graduate medical education costs

The term "direct graduate medical education costs" means direct costs of approved educational activities for approved medical residency training programs.

(D) Foreign medical graduate

The term "foreign medical graduate" means a resident who is not a graduate of—

(i) a school of medicine accredited by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges (or approved by such Committee as meeting the standards necessary for such accreditation),

(ii) a school of osteopathy accredited by the American Osteopathic Association,

or approved by such Association as meeting the standards necessary for such accreditation, or

(ii) a school of dentistry or podiatry which is accredited (or meets the standards for accreditation) by an organization recognized by the Secretary for such purpose.

(E) FMGEMS examination

The term "FMGEMS examination" means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences or any successor examination recognized by the Secretary for this purpose.

(F) Initial residency period

The term "initial residency period" means the period of board eligibility plus one year, except that—

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.

The initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.

(G) Period of board eligibility

(i) General rule

Subject to clauses (ii) and (iii), the term "period of board eligibility" means, for a resident, the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.

(ii) Application of 1985-1986 Directory

Except as provided in clause (iii), the period of board eligibility shall be such period specified in the 1985-1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education.

(iii) Changes in period of board eligibility

On or after July 1, 1989, if the Accreditation Council on Graduate Medical Education, in its Directory of Residency Training Programs—

(I) increases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, above the period specified in its 1985-1986 Directory, the Secretary may increase the period of board eligibility for that specialty, but not to exceed the period of board eligibility specified in that later Directory, or

(II) decreases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, below the period specified in its 1985-1986 Directory, the Secretary

may decrease the period of board eligibility for that specialty, but not below the period of board eligibility specified in that later Directory.

(H) Primary care resident

The term "primary care resident" means a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice.

(I) Resident

The term "resident" includes an intern or other participant in an approved medical residency training program.

(J) Adjustments for certain family practice residency programs

(i) In general

In the case of an approved medical residency training program (meeting the requirements of clause (ii)) of a hospital which received funds from the United States, a State, or a political subdivision of a State or an instrumentality of such a State or political subdivision (other than payments under this subchapter or a State plan under subchapter XIX of this chapter) for the program during the cost reporting period that began during fiscal year 1984, the Secretary shall—

(I) provide for an average amount under paragraph (2)(A) that takes into account the Secretary's estimate of the amount that would have been recognized as reasonable under this

subchapter if the hospital had not received such funds, and

(II) reduce the payment amount otherwise provided under this subsection in an amount equal to the proportion of such program funds received during the cost reporting period involved that is allocable to this subchapter.

(ii) Additional requirements

A hospital's approved medical residency program meets the requirements of this clause if—

(I) the program is limited to training for family and community medicine;

(II) the program is the only approved medical residency program of the hospital; and

(III) the average amount determined under paragraph (2)(A) for the hospital (as determined without regard to the increase in such amount described in clause (i)(I)) does not exceed $10,000.

2. 42 U.S.C. § 1395oo provides in relevant part:

(a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing wth respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") * * * if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report

* * * *

(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received.

* * * *

Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205.

3. 42 U.S.C. § 1395ww(a)(1)(C) provides:

The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this subchapter for

such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

4. 42 U.S.C. § 1395ww(a)(4) provides in relevant part:

For purposes of this section, the term "operating costs of inpatient hospital services" includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis (as determined by the Secretary) * * *. Such term does not include costs of approved educational activities * * *.

5. 42 U.S.C. § 1395ww(b)(3)(A) provides:

Except as provided in subparagraphs (C), (D), and (E), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

6. 42 C.F.R. § 405.481(g) (1985) provides in relevant part:

(g) *Recordkeeping requirements.* * * *, each provider that claims payment for services of physicians under this subpart must:

* * * *

(3) Retain each physician compensation allocation, and the information on which it is based, for at least four years after the end of each reporting period to which the allocation applies.

7. 42 C.F.R. § 405.1801(a)(1) (1985) provides in relevant part:

(a) *Definitions.*

* * * *

"Intermediary determination" means the following:

(1) With respect to a provider of services that has filed a cost report under §§ 405.406 and 405.453(f), the term means a determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

8. 42 C.F.R. § 405.1803(a)(1) and (b) (1985) provides:

Intermediary determination and notice of amount of program reimbursement.

(a) *General requirement.* Upon receipt of a provider's cost report, or amended cost report where permitted or required, the intermediary must within a reasonable period of time (see § 405.1835(b)), furnish the provider and other parties as appropriate (see § 405.1805) a

written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider. The intermediary must include the following information in the notice, as appropriate:

(1) *Reasonable cost.* The notice must—

(i) Explain the intermediary's determination of total program reimbursement due the provider on the basis of reasonable cost for the reporting period covered by the cost report or amended cost report; and

(ii) Relate this determination to the provider's claimed total program reimbursement due the provider for this period.

* * * *

(b) *Requirements for intermediary notices.* The intermediary must include in each notice appropriate references to law, regulations, HCFA Rulings, or program instructions to explain why the intermediary's determination of the amount of program reimbursement for the period differs from the amount the provider claimed. The notice must also inform the provider of its right to an intermediary or Board hearing (see §§ 405.1809, 405.1811, 405.1815, 405.1835, and 405.1843) and that the provider must request the hearing within 180 days after the date of the notice.

9. 42 C.F.R. § 405.1807 (1985) provides:

Effect of intermediary determination.

The determination shall be final and binding on the party or parties to such determination unless:

(a) An intermediary hearing is requested in accordance with § 405.1811 and an intermediary hearing decision rendered in accordance with § 405.1831; or

(b) The intermediary determination is revised in accordance with § 405.1885; or

(c) A Board hearing is requested in accordance with § 405.1835 and a hearing decision rendered pursuant thereto.

10. 42 C.F.R. § 405.1885(a) (1985) provides in relevant part:

A determination of an intermediary * * * may be reopened with respect to findings on matters at issue in such determination * * * by such intermediary officer * * * either on motion of such intermediary officer * * * or on the motion of the provider affected by such determination * * * to revise any matter in issue at any such proceedings. * * * any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

11. 42 C.F.R. § 412.71(d) (1985) provides in relevant part:

Intermediary's determination. * * *. The intermediary's estimate of base-year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided in § 412.72.

12. 42 C.F.R. § 412.113(b) (1985) provides in relevant part: [1]

Direct medical education costs. Payment for the cost of approved medical educational activities as defined in § 405.421 of this chapter is made on a reasonable cost basis * * *. For cost reporting periods beginning before October 1, 1986, the costs of medical education must be determined consistently with the treatment of such costs

[1] 42 C.F.R. § 412.113(b), as published at 54 Fed. Reg. 40,315 (1989) and corrected at 55 Fed. Reg. 299 (1990), is reproduced in its entirety in the Joint Appendix at 26.

for purposes of determining the hospital-specific portion of the transition payment rate in Subpart E of this part.

13. 42 C.F.R. § 413.86(e)(1) provides in relevant part: [2]

Determining per resident amounts for the base period— (1) *For the base period.* (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

* * * *

(ii) In determining the base-period per resident amount under paragraph (e)(1)(i) of this section, the intermediary—

(A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;

(B) Excludes from the base-period graduate medical education costs any nonallowable or misclassified costs, including those previously allowed under § 412.113(b)(3) of this chapter; and

(C) Upon a hospital's request, includes graduate medical education costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under § 412.113(b)(3) of this chapter during the graduate medical education base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(2) of this section.

[2] 42 C.F.R. § 413.86, as published at 54 Fed. Reg. 40,316-40,319 (1989) and corrected at 55 Fed. Reg. 299 (1990), is reproduced in its entirety in the Joint Appendix at 26-38.

(iii) If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

(iv) If the intermediary modifies a hospital's base-period graduate medical education costs as described in paragraph (e)(1)(ii)(B) of this section, the hospital may request an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(1) of this section.